

General Instructions for Completing Budget Forms DSHS Costs Only Budgeted on Detail Category Pages

(Examples and instructions for completing the Budget Category Detail Templates are in a separate Excel file located under Templates for Cost Reimbursement Budgets located at :

<http://www.dshs.state.tx.us/grants/forms.shtm>

- * Enter the legal name of your organization in the space provided for "Legal Name of Respondent" on Form I -Budget Summary; doing so will populate the budget category detail templates with your organizations name.
- * Complete each budget category detail template. Instructions for completing each budget category detail template are in a separate document. If a primary budget category detail template does not accommodate all items in your budget, use the respective supplemental budget template at the end of this workbook. The total of each supplemental category detail budget template will automatically populate to the last line of the respective primary budget category template.
- * After you have completed each budget category detail form, go to Form I-Budget Summary and input other sources of funding manually (if any) in Columns 3 - 6 for each budget category.
- * Refer to the table below the budget template table to verify that the amounts distributed ("Distribution Total") in each budget category equals the "Budget Total" for each respective category. Next, verify that the overall total of all distributions ("Distribution Totals") equals the Budget Total.
- * Enter the total amount of "Program Income" anticipated for this program in row "K" under the "Total Budget" column (1). The total program income budgeted will be automatically allocated to each funding source based on the percentage of funding of the total budget. Information on program income is available in the DSHS Contractors Financial Procedures Manual located at the following web site:
<http://www.dshs.state.tx.us/contracts/>

FORM I: BUDGET SUMMARY (REQUIRED)

Legal Name of Respondent:

Fort Bend County-HHS001057600019-OHDPP/COVID-LHD-FY22-23-Approved

Budget Categories	Total Budget (1)	DSHS Funds Requested (2)	Direct Federal Funds (3)	Other State Agency Funds* (4)	Local Funding Sources (5)	Other Funds (6)
A. Personnel	\$543,450	\$543,450	\$0	\$0	\$0	\$0
B. Fringe Benefits	\$312,419	\$312,419	\$0	\$0	\$0	\$0
C. Travel	\$10,931	\$10,931	\$0	\$0	\$0	\$0
D. Equipment	\$0	\$0	\$0	\$0	\$0	\$0
E. Supplies	\$5,200	\$5,200	\$0	\$0	\$0	\$0
F. Contractual	\$0	\$0	\$0	\$0	\$0	\$0
G. Other	\$3,000	\$3,000	\$0	\$0	\$0	\$0
H. Total Direct Costs	\$875,000	\$875,000	\$0	\$0	\$0	\$0
I. Indirect Costs	\$0	\$0	\$0	\$0	\$0	\$0
J. Total (Sum of H and I)	\$875,000	\$875,000	\$0	\$0	\$0	\$0
K. Program Income - Projected Earnings	\$0	\$0				

NOTE: The "Total Budget" amount for each Budget Category will have to be allocated (entered) manually among the funding sources. Enter amounts in whole dollars. After amounts have been entered for each funding source, verify that the "Distribution Total" below equals the respective amount under the "Total Budget" from column (1).

	Budget Category	Distribution Total	Budget Total	Budget Category	Distribution Total	Budget Total
Check Totals For:	Personnel	\$543,450	\$543,450	Fringe Benefits	\$312,419	\$312,419
	Travel	\$10,931	\$10,931	Equipment	\$0	\$0
	Supplies	\$5,200	\$5,200	Contractual	\$0	\$0
	Other	\$3,000	\$3,000	Indirect Costs	\$0	\$0

TOTAL FOR:	Distribution Totals	\$875,000	Budget Total	\$875,000
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*Letter(s) of good standing that validate the respondent's programmatic, administrative, and financial capability must be placed after this form if respondent receives any funding from state agencies other than DSHS related to this project. If the respondent is a state agency or institution of higher education, letter(s) of good standing are not required. DO NOT include funding from other state agencies in column 4 or Federal sources in column 3 that is not related to activities being funded by this DSHS project.

FORM I-1: PERSONNEL Budget Category Detail Form

Legal Name of Respondent:

Fort Bend County-HHS001057600019-OHDPP/COVID-LHD-FY22-23-Approved

PERSONNEL	Vacant Y/N	Justification	FTE's	Certification or License (Enter NA if not required)	Total Average Monthly Salary/Wage	Number of Months	Salary/Wages Requested for Project
Functional Title + Code E = Existing or P = Proposed							
Health Equity Manager P	Y	To manage the efforts of this program. Will be responsible for evaluating data on communities with higher impacts from COVID and with less vaccinations. Will direct efforts to engage the communities and increase vaccination awareness, counter myths and organize vaccine outreach	1	NA	\$6,666.67	21	\$140,000
Community Health Worker (part-time) P	Y	To work in the communities most affected and provide (and gather) important information regarding vaccines, and promote accurate information, dispelling myths and inaccuracies. Assist with bridging access gaps where needed.	0.6	CHW	\$3,428.57	21	\$43,200
Community Health Worker (mental health) P	Y	To work in the communities most affected and provide (and gather) important information regarding vaccines, and promote accurate information, dispelling myths and inaccuracies. Use knowledge and experience of mental health issues to bridge access gaps.	1	CHW	\$3,166.67	21	\$66,500
Outreach Communications Specialist	Y	Assist the team with appropriate messaging, flyers, social media infographics, to address the concerns raised with data analysis, community input and CHW findings.	1	NA	\$3,750.00	17	\$63,750
							\$0
Public Health Fellowship Positions	Y	5 positions from June 1, 2022 - May 31, 2023	5	Various for the positions	\$3,833.33	12	\$230,000
							\$0
							\$0

Revised: 7/6/2009

							\$0
							\$0
							\$0
							\$0
							\$0
TOTAL FROM PERSONNEL SUPPLEMENTAL BUDGET SHEETS							\$0
SalaryWage Total							\$543,450

FRINGE BENEFITS		Itemize the elements of fringe benefits in the space below:	
FICA = 7.65% x Salary = \$23,978.92 Pension = 13.45% x Salary = \$42,159.02 WC/Unemp = 0.38% x Salary = \$11,911.10 Health Insurance = \$16,100 x FTE/year = \$96,600			
		Fringe Benefit Rate %	57.49%
		Fringe Benefits Total	\$312,419

FORM I-2: TRAVEL Budget Category Detail Form

Legal Name of Respondent:

Fort Bend County-HHS001057600019-OHDPP/COVID-LHD-FY22-23-Approved

Conference / Workshop Travel Costs					
Description of Conference/Workshop	Justification	Location City/State	Number of:	Travel Costs	
			Days/Employees		
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	\$0
TOTAL FROM TRAVEL SUPPLEMENTAL CONFERENCE/WORKSHOP BUDGET SHEETS					\$0

Total for Conference / Workshop Travel

\$0

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
Mileage Reimbursement for program staff traveling to communities for outreach work	6609	\$0.560	\$3,701		\$3,701
Mileage Reimbursement for the Public Health Fellowship Positions	12910	\$0.560	\$7,230		\$7,230
			\$0		\$0
			\$0		\$0
			\$0		\$0
			\$0		\$0
			\$0		\$0
TOTAL FROM TRAVEL SUPPLEMENTAL OTHER/LOCAL TRAVEL COSTS BUDGET SHEETS					\$0

Total for Other / Local Travel

\$10,931

Other / Local Travel Costs: \$10,931

Conference / Workshop Travel Costs: \$0

Total Travel Costs: \$10,931

Indicate Policy Used:

Respondent's Travel Policy ☒State of Texas Travel Policy ☐

Revised: 7/6/2009

**FORM I-3: EQUIPMENT AND CONTROLLED ASSETS Budget Category
Detail Form**

Legal Name of Respondent:

Fort Bend County-HHS001057600019-OHDPP/COVID-LHD-FY22-23-Approved

Itemize, describe and justify the list below. Attach complete specifications or a copy of the purchase order. See attached example for equipment definition and detailed instructions to complete this form.

Description of Item	Purpose & Justification	Number of Units	Cost Per Unit	Total
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
TOTAL FROM EQUIPMENT SUPPLEMENTAL BUDGET SHEETS				\$0

Total Amount Requested for Equipment:

\$0

FORM I-4: SUPPLIES Budget Category Detail Form

Legal Name of Respondent:

Fort Bend County-HHS001057600019-OHDPP/COVID-LHD-FY22-23-Approved

Itemize and describe each supply item and **provide an estimated quantity and cost (i.e. #of boxes & cost/box) if applicable.** Provide a justification for each supply item. Costs may be categorized by each general type (e.g., office, computer, medical, educational, etc.) See attached example for definition of supplies and detailed instructions to complete this form.

Description of Item [If applicable, provide estimated quantity and cost (i.e. # of boxes & cost/box)]	Purpose & Justification	Total Cost
Promotional materials for communities to include language appropriate, printing, laminating, etc	To provide accurate and persuasive information to the communities at most risk for impact of COVID-19	\$4,000
Chairs	Office chairs for staff 4 x \$300	\$1,200
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
	TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS	\$0

Total Amount Requested for Supplies:

\$5,200

FORM I-5: CONTRACTUAL Budget Category Detail Form

Legal Name of Respondent: Fort Bend County-HHS001057600019-OHDPP/COVID-LHD-FY22-23-Approved

List contracts for services related to the scope of work that is to be provided by a third party. If a third party is not yet identified, describe the service to be contracted and show contractors as "To Be Named." Justification for any contract that delegates \$100,000 or more of the scope of the project in the respondent's funding request, must be attached behind this form.

CONTRACTOR NAME (Agency or Individual)	DESCRIPTION OF SERVICES (Scope of Work)	Justification	METHOD OF PAYMENT (i.e., Monthly, Hourly, Unit, Lump Sum)	# of Months, Hours, Units, etc.	RATE OF PAYMENT (i.e., hourly rate, unit rate, lump sum amount)	TOTAL
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
TOTAL FROM CONTRACTUAL SUPPLEMENTAL BUDGET SHEETS						\$0

Total Amount Requested for CONTRACTUAL:

\$0

FORM I-6: OTHER Budget Category Detail Form

Legal Name of Respondent:

Fort Bend County-HHS001057600019-OHDPP/COVID-LHD-FY22-23-Approved

Description of Item [If applicable, include quantity and cost/quantity (i.e. # of units & cost per unit)]	Purpose & Justification	Total Cost
Phone service	For communcation with team members in the field and office	\$3,000
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
		\$0
TOTAL FROM OTHER SUPPLEMENTAL BUDGET SHEETS		\$0

Total Amount Requested for Other:

\$3,000

FORM I - 7 Indirect Costs

Legal Name of Respondent:

Fort Bend County-HHS001057600019-OHDPP/COVID-LHD-FY22-23-

Total amount of indirect costs allocable to the project:

Amount:

\$0

Indirect costs are based on (mark the statement that is applicable):

_____ The respondent's most recent indirect cost rate approved by a federal cognizant agency or state single audit coordinating agency. **Expired rate agreements are not acceptable. Attach a copy of the rate agreement to this form (Form I - 7 Indirect)**

RATE:

BASE:

_____ ***Applies only to governmental entities***. The respondent's current central service cost rate or indirect cost rate based on a rate proposal prepared in accordance with OMB Circular A-87. **Attach a copy of Certification of Cost Allocation Plan or Certification of Indirect Costs.**

RATE:

TYPE:

BASE:

_____ **Note:** Governmental units with only a Central Service Cost Rate must also include the indirect cost of the governmental units department (i.e. Health Department). In this case indirect costs will be comprised of central service costs (determined by applying the rate) and the indirect costs of the governmental department. The allocation of indirect costs must be addressed in Part V - Indirect Cost Allocation of the Cost Allocation Plan that is submitted to DSHS.

_____ A cost allocation plan. A cost allocation plan as specified in the DSHS Contractor's Financial Procedures Manual (CFPM), Appendix A must be submitted to DSHS within 60 days of the contract start date. The CFPM is available on the following internet web link: <http://www.dshs.state.tx.us/contracts/>

GO TO PAGE 2 (below)

Page 2, FORM I - 7 Indirect Costs

If using an central service or indirect cost rate, identify the types of costs that are included (being allocated) in the rate:

Organizations that do not use an indirect cost rate and governmental entities with only a central service rate must identify the types of costs that will be allocated as indirect costs and the methodology used to allocate these costs in the space provided below. The costs/methodology must also be disclosed in Part V-Indirect Cost Allocation of the Cost Allocation Plan that is submitted to DSHS. **Identify the types of costs that are being allocated as indirect costs, the allocation methodology, and the allocation base:**

SUPPLEMENTAL FORMS INSTRUCTIONS

The budget templates (two per budget category) that follow are intended to supplement cost reimbursement budgets when there are too many items to fit on the primary budget template. Applicants that have utilized all the lines on the primary budget template must use the supplemental templates to list detail information for the respective budget category. For example, after all the lines on the primary budget template for Personnel (tab labeled Form I - 1 Personnel) have been used, go to the supplemental template labeled "Form I - 1a Personnel Supp" and if all the lines are used on this template, go to the next template labeled "Form I - 1b Personnel". The amounts on each supplemental template will automatically total and the total from both templates will automatically be inserted on the last line of the primary budget template.

The supplemental budget templates are:

- Form I-1 Personnel Supplemental
- Form I-2 Travel Supplemental
- Form I-3 Equipment Supplemental
- Form I-4 Supplies Supplemental
- Form I-5 Contractual Supplemental
- Form I-6 Other Supplemental

FORM I-1: PERSONNEL Budget Category Detail Form (Supplemental)

Legal Name of Respondent:

Fort Bend County-HHS001057600019-OHDPP/COVID-LHD-FY22-23-Approved

PERSONNEL							
Functional Title + Code E = Existing or P = Proposed	Vacant Y/N	Justification	FTE's	Certification or License (Enter NA if not required)	Total Average Monthly Salary/Wage	Number of Months	Salary/Wages Requested for Project
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
						SalaryWage Total	\$0

FORM I-1: PERSONNEL Budget Category Detail Form (Supplemental)

Legal Name of Respondent:

Fort Bend County-HHS001057600019-OHDPP/COVID-LHD-FY22-23-Approved

PERSONNEL							
Functional Title + Code E = Existing or P = Proposed	Vacant Y/N	Justification	FTE's	Certification or License (Enter NA if not required)	Total Average Monthly Salary/Wage	Number of Months	Salary/Wages Requested for Project
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
							\$0
						SalaryWage Total	\$0

FORM I-2: TRAVEL Budget Category Detail Form (Supplemental)

Legal Name of Respondent:

Fort Bend County-HHS001057600019-OHDPP/COVID-LHD-FY22-23-Approved

Conference / Workshop Travel Costs

Description of Conference/Workshop	Justification	Location (City, State)	Number of: Days/Employees	Travel Costs	
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	\$0

Total for Conference / Workshop Travel

\$0

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
			\$0		\$0
			\$0		\$0
			\$0		\$0
			\$0		\$0
			\$0		\$0
			\$0		\$0
			\$0		\$0
			\$0		\$0
			\$0		\$0

Total for Other / Local Travel**\$0**Other / Local Travel Costs: **\$0**Conference / Workshop Travel Costs: **\$0****Total Travel Costs:****\$0**

FORM I-2: TRAVEL Budget Category Detail Form (Supplemental)

Legal Name of Respondent:

Fort Bend County-HHS001057600019-OHDPP/COVID-LHD-FY22-23-Approved

Conference / Workshop Travel Costs

Description of Conference/Workshop	Justification	Location (City, State)	Number of: Days/Employees	Travel Costs	
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	\$0
				Mileage	
				Airfare	
				Meals	
				Lodging	
				Other Costs	
				Total	\$0

Total for Conference / Workshop Travel

\$0

Other / Local Travel Costs

Justification	Number of Miles	Mileage Reimbursement Rate	Mileage Cost (a)	Other Costs (b)	Total (a) + (b)
			\$0		\$0
			\$0		\$0
			\$0		\$0
			\$0		\$0
			\$0		\$0
			\$0		\$0
			\$0		\$0
			\$0		\$0
			\$0		\$0

Total for Other / Local Travel**\$0**Other / Local Travel Costs: **\$0**Conference / Workshop Travel Costs: **\$0****Total Travel Costs:****\$0**

FORM I-3: EQUIPMENT AND CONTROLLED ASSETS Budget Category
Detail Form (Supplemental)

Legal Name of Respondent:

Fort Bend County-HHS001057600019-OHDPP/COVID-LHD-FY22-23-Approved

Itemize, describe and justify the list below. Attach complete specifications or a copy of the purchase order. See attached example for equipment definition and detailed instructions to complete this form.

Description of Item	Purpose & Justification	Number of Units	Cost Per Unit	Total
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0

Total Amount Requested for Equipment:

\$0

FORM I-3: EQUIPMENT AND CONTROLLED ASSETS Budget Category
Detail Form (Supplemental)

Legal Name of Respondent:

Fort Bend County-HHS001057600019-OHDPP/COVID-LHD-FY22-23-Approved

Itemize, describe and justify the list below. Attach complete specifications or a copy of the purchase order. See attached example for equipment definition and detailed instructions to complete this form.

Description of Item	Purpose & Justification	Number of Units	Cost Per Unit	Total
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0

Total Amount Requested for Equipment:

\$0

FORM I-4: SUPPLIES Budget Category Detail Form (Supplemental)

Legal Name of Respondent:

Fort Bend County-HHS001057600019-OHDPP/COVID-LHD-FY22-23-Approved

Itemize and describe each supply item and **provide an estimated quantity and cost (i.e. # of boxes & cost/box) if applicable**. Provide a justification for each supply item. Costs may be categorized by each general type (i.e., office, computer, medical, client incentives, educational, etc.)

Description of Item [If applicable, provide estimated quantity and cost (i.e. # of boxes & cost/box)]	Purpose & Justification	Total Cost

Total Amount Requested for Supplies:

\$0

FORM I-4: SUPPLIES Budget Category Detail Form (Supplemental)

Legal Name of Respondent:

Fort Bend County-HHS001057600019-OHDPP/COVID-LHD-FY22-23-Approved

Itemize and describe each supply item and **provide an estimated quantity and cost (i.e. # of boxes & cost/box) if applicable**. Provide a justification for each supply item. Costs may be categorized by each general type (i.e., office, computer, medical, client incentives, educational, etc.)

Description of Item [If applicable, provide estimated quantity and cost (i.e. # of boxes & cost/box)]	Purpose & Justification	Total Cost

Total Amount Requested for Supplies:

\$0

FORM I-5: CONTRACTUAL Budget Category Detail Form (Supplemental)

Legal Name of Respondent:

Fort Bend County-HHS001057600019-OHDPP/COVID-LHD-FY22-23-Approved

List contracts for services related to the scope of work that is to be provided by a third party. If a third party is not yet identified, describe the service to be contracted and show contractors as "To Be Named." Justification for any contract that delegates \$100,000 or more of the scope of the project in the respondent's funding request, must be attached behind this form.

CONTRACTOR NAME (Agency or Individual)	DESCRIPTION OF SERVICES (Scope of Work)	Justification	METHOD OF PAYMENT (i.e. Monthly, Hourly, Unit, Lump Sum)	# of Months, Hours, Units, etc.	RATE OF PAYMENT (i.e. hourly rate, unit rate, lump sum amount)	TOTAL
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0

Total Amount Requested for CONTRACTUAL:

\$0

FORM I-5: CONTRACTUAL Budget Category Detail Form (Supplemental)

Legal Name of Respondent:

Fort Bend County-HHS001057600019-OHDPP/COVID-LHD-FY22-23-Approved

List contracts for services related to the scope of work that is to be provided by a third party. If a third party is not yet identified, describe the service to be contracted and show contractors as "To Be Named." Justification for any contract that delegates \$100,000 or more of the scope of the project in the respondent's funding request, must be attached behind this form.

CONTRACTOR NAME (Agency or Individual)	DESCRIPTION OF SERVICES (Scope of Work)	Justification	METHOD OF PAYMENT (i.e. Monthly, Hourly, Unit, Lump Sum)	# of Months, Hours, Units, etc.	RATE OF PAYMENT (i.e. hourly rate, unit rate, lump sum amount)	TOTAL
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0

Total Amount Requested for CONTRACTUAL:

\$0

FORM I-6: OTHER Budget Category Detail Form (Supplemental)

Legal Name of Respondent:

Fort Bend County-HHS001057600019-OHDPP/COVID-LHD-FY22-23-Approved

Description of Item [If applicable, include quantity and cost/quantity (i.e. # of units & cost/unit)]	Purpose & Justification	Total Cost

Total Amount Requested for Other:

\$0

FORM I-6: OTHER Budget Category Detail Form (Supplemental)

Legal Name of Respondent:

Fort Bend County-HHS001057600019-OHDPP/COVID-LHD-FY22-23-Approved

Description of Item [If applicable, include quantity and cost/quantity (i.e. # of units & cost/unit)]	Purpose & Justification	Total Cost

Total Amount Requested for Other:

\$0